Staff perceptions of Borderline Personality Disorder and recovery: A Q-sort method approach

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Abstract

Objectives: This study was the first to explore how staff that work with people diagnosed with borderline personality disorder (BPD) perceive recovery in this client group. These views are important because of the crucial role that staff play in the care of people with BPD, and the challenges that staff experience with these clients.

Design: A Q methodology design was used, containing 58 statements about recovery.

Methods: Twenty-nine mental health staff sorted recovery statements according to perceived importance to recovery in BPD.

Results: There were two different viewpoints about recovery in BPD. A medically oriented group viewed coping with symptoms and behaviours specific to BPD as being most important to recovery, whereas participants who were more well-being oriented viewed achieving overall well-being that was universally valued regardless of diagnosis as more important. Both groups reported that engaging in socially-valued activities such as work and education was not an important aspect of recovery and that people with BPD could be considered to have recovered despite continued impairments in everyday functioning.

Conclusions: Staff perceptions of recovery in BPD can differ, which poses risks for consistent team working, a particularly important issue in this client group due to the relational difficulties associated with the diagnosis. Multidisciplinary teams working with people diagnosed with BPD therefore need to find a forum to promote a shared understanding of each patient's needs and support plans. We advocate that team formulation is a promising approach to achieve more consistent ways of working within teams.

Practitioner points:

Findings

- Multi-disciplinary teams working with people with borderline personality disorder should use team formulations to create a shared understanding of individual patient's needs and goals for recovery, so they can deliver a consistent approach to care.
- Recovery questionnaires should be used to develop an understanding of a patient's individual recovery goals.

Limitations

- Opportunity sampling was utilised in recruitment, and the sample was not representative of general population of staff working with borderline personality disorder.
- Although views from a wide range of professions were sampled in this research, the views of psychiatrists were not represented.

Borderline personality disorder is defined as 'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood' (American Psychiatric Association, 2013). Recovery is an important topic within personality disorder research as it is often viewed as an untreatable condition (Paris, 2012). Within serious mental illness, two main perspectives of recovery have been uncovered: the medical perspective of recovery which revolves around the central idea of symptom reduction and a return to prior functioning, and the perspective of recovery informed by the mental health consumer/survivor movement, which views mental illness as being only one small aspect of a person's life and advocates for empowerment, development of a positive identity, and having goals and aspirations regardless of experience of symptoms (Davidson, O'Connell, Tondora, Lawless & Evans, 2005).

Medicalised models of recovery focusing on symptoms and illness are traditionally utilised by medical professionals (Deegan, 1996), and these are often applied within services that treat personality disorder. Dialectical Behaviour Therapy (DBT) is one of the most common psychological interventions for borderline personality disorder and aims to work on 'target problem behaviours' through helping clients learn skills in distress tolerance, mindfulness, emotion-regulation and interpersonal effectiveness (Linehan, 2015). However,

research has found that despite interventions such as DBT leading to reductions in behaviours associated with a diagnosis of borderline personality disorder (e.g. self-harming behaviours), deficits in social factors such as interpersonal relationships and vocational impairment remain (Zanarini et al., 2007). These continuing difficulties after intervention show a disconnection between the medical models of recovery and the realities of recovery in borderline personality disorder.

Due to the mental health consumer/survivor movement, a more well-being oriented definition of recovery has been introduced, and there has been a shift in mental health away from medical model perspectives towards a focus on health, wellness and strengths (Davidson et al., 2005; Shepherd, Boardman, & Slade, 2008). This shift includes greater collaboration between clients and professionals in choice and intervention options, recognition of clients as experts, and the development of roles such as experts by experience and service user researchers (D'Sa & Rigby, 2011; Pitt, Kilbride, Nothard, Welford, & Morrison, 2007). This paradigm shift embraces personal recovery principles, which encompass the ability to achieve a state of general well-being, regardless of the individual's experience of mental health difficulties (Yates, Holmes, & Priest, 2012).

However, it has been argued that these principles may not apply so readily to personality disorder as differences between personality disorder and other mental health difficulties may impact upon definitions of recovery, and the practices that lead to its achievement (Green, Batsman, & Gudjonsson, 2011; Gudjonsson, Webster, & Green, 2010; Turner, Lovell, & Brokker, 2011). For example, the ego-syntonic nature of personality disorder means that many patients may not perceive their behaviours to be inappropriate and do not recognise them as a problem, making interventions that try to help more difficult, at least

initially (Williams, 2006). The intrinsic relationship difficulties in personality disorder can also present problems in the therapeutic relationships between patients and staff due to boundary issues (National Collaborating Centre for Mental Health, 2009) that may impact upon the strength of an alliance between therapist and patient, potentially resulting in poorer outcomes (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

Little research has been conducted to explore perspectives of recovery in borderline personality disorder. A recent systematic review by Ng, Bourke, and Grenyer (2016) aimed to understand how patients, clinicians, family, and carers perceived recovery from borderline personality disorder. The review identified 16 longitudinal quantitative studies with 11 unique cohorts, and three qualitative studies (Larivière et al., 2015; Katsakou et al., 2012; Holm & Severinsson, 2011) that examined recovery in borderline personality disorder. Quantitative studies tended to define recovery in terms of clinical remission from diagnostic criteria, and level of functioning as measured through scales such as the Health-Sickness Rating Scale (Luborsky, 1962). The qualitative studies all explored patient perceptions of their recovery, and discovered three broad themes: active willingness to engage in recovery journey, improving on clinical characteristics of borderline personality disorder to facilitate change, and the conceptualisation of recovery. Participants highlighted the importance of engaging in meaningful activities such as education or employment, and an improved understanding of their diagnosis through therapy and psychoeducation. The need to improve emotional regulation, develop an identity and improve interpersonal skills and relationships were emphasised as significant factors for further change. Two studies discovered that patients believed that the word ‘recovery’ was not representative of their experiences, instead conceptualising it as a journey leading to improved well-being (Larivière et al., 2015; Katsakou et al., 2012). Overall, Ng et al. (2016) found a greater emphasis on symptomatic remission as

an indicator of recovery compared to other mental health problems. Despite the aims of the review, Ng et al. (2016) was unable to identify any articles that explored the perspectives of clinicians, family or carers. This highlights the necessity for researchers to examine the perspectives of these groups, as they all play an integral role in the recovery of patients with borderline personality disorder.

Understanding staff perceptions of recovery in borderline personality disorder is especially important because patients with borderline personality disorder have been described as the patients that staff may dislike or find challenging to work with (Lewis & Appleby, 1988; Chartonas, Kyratsous, Dracass, Lee, & Bhui, 2017). Evidence shows that staff members tend to misunderstand personality disorder, and feel that patients are seeking attention, manipulating them and are more in control of their behaviours than other people with mental health difficulties (Markham & Trower, 2003; Nehls, 1999). Consequently, these beliefs may impact upon staff's understanding of recovery in borderline personality disorder.

Q methodology can be used to investigate "complex and socially contested concepts" (Watts & Stenner, 2005), such as recovery. It has previously been used to identify the diversity of perspectives surrounding recovery in other mental health problems such as psychosis (Wood, Price, Morrison, & Haddock, 2013). The aim of the current study is to explore and understand perceptions of recovery in staff who work with patients diagnosed with borderline personality disorder, using Q methodology. The study also aimed to determine the most important factors to recovery and establish whether these are in line with personal recovery principles in the context of other mental health problems.

Method

Overview of Q methodology

A Q set is developed from the concourse, which consists of the everyday discourse surrounding a particular topic analysed for themes (Brown, 1993). Statements representing each theme are sampled, creating the Q set. Participants are required to sort each statement according to importance. Shared viewpoints are identified through factor analytic techniques, identifying groups of participants who have ranked statements in a similar way. The aim is to uncover collective opinions, highlighting shared perceptions among participants.

Existing literature and development of concourse

A literature review was undertaken using PsycInfo, PubMed and Google Scholar search engines to explore and sample the concourse. The term 'recovery' was entered in addition to 'mental illness', 'borderline personality disorder' and 'recovery measure'. Qualitative research (e.g. Castillo, Ramon, & Morant, 2013; Katsakou et al., 2012), existing recovery questionnaires (e.g. Mental Health Recovery Star; MacKeith & Burns, 2010), and white paper documents on recovery were examined (e.g. Shepherd et al., 2008) from the literature search. The resulting concourse reflected opinions, beliefs and ideas relating to recovery and included direct quotes, research findings and questionnaire items, which were used to derive approximately 400 statements.

Development of Q set

A list of items was generated (the Q set), creating a miniature but representative version of the concourse. Statements under each theme from the concourse were reviewed by the research team and two experts by experience for repetition, representativeness of themes, and

clarity. Following several reviews, 58 statements from the original 400 items, grouped under 14 different themes were agreed for inclusion in the final Q set (Table 1).

Participants

Inclusion criteria for participation were: over six months experience working with patients with borderline personality disorder, over 18 years old, and ability to read and speak English. Opportunity sampling was used to recruit participants through psychotherapy departments, community mental health teams, and clinical academics within a UK university. Social media was also utilised for recruitment. Information sheets were distributed to staff within targeted services, and those interested made contact with the researcher.

A total of 29 staff members were recruited from a variety of services and professional groups to ensure a representative sample. Participants' professions are outlined in Table 2, additional demographic information for all participants in Table 3, and a comparison of demographics across resulting factors in Table 4.

Procedure

Participants were asked to provide basic demographic details, and information about their professional role working with patients with borderline personality disorder. Participants were then presented with the 58 statements in a randomized order and a forced-choice Q-sort grid (Figure 1). They were asked to sort statements in terms of importance in relation to the following question: *What factors are most important for recovery in borderline personality disorder?*

Participants completed an initial sort into three categories: *important, not important* and *neutral*. They then took statements from the *important* pile and selected the three statements that they considered to be most important. They placed these on the farthest column of the distribution grid (+5). Participants took the next four statements that they most agreed with from the pile and continued to work inwards until they had sorted all '*important'* statements. Participants were given the same instructions for the '*not important*' pile; starting with the three statements considered least important, and placing these on the other side of the grid (-5). Participants were then asked to sort the remaining neutral statements by placing the ones that they did not feel strongly about in the central column and working either outwards or inwards.

After the sorting process participants took part in a short semi-structured interview and were asked to reflect on their decisions. Participants were asked: 1) How did you find completing the Q-sort? 2) Were there any statements which stood out to you? 3) Please expand on your three most agreed statements? 4) Please expand on your three most disagreed statements? 5) Was there anything you feel is important that was not included in the Q-sort? These reflections were audio recorded, transcribed, and used to embellish the quantitative analysis.

Analysis

Data Analysis

A Q methodology statistical programme (PQMethod Version 2.35; Schmolck, 2002) was used to analyse the data. Principal components analysis with varimax rotation was executed to identify factors and explain the maximum amount of variance. Q method analysis factors groups of people together, as opposed to items in traditional factor analysis.

Results

Most important recovery statements

Frequency counts and percentages for each statement are given in Table 5. The most frequently endorsed items were 'being able to get on with life, despite having difficulties', and 'being able to cope with strong feelings (e.g. feeling sad or angry)'. No participants endorsed 'having no difficulties', and only one participant endorsed 'being in employment (paid or unpaid)', 'being medication free', and 'having religion and/or faith'.

Factor Analysis

A scree test was used to determine how many factors had been discovered. A two-factor solution provided the best fit of the data, explaining 46% of the variance. Twenty-eight out of 29 participants loaded onto at least one factor. One participant did not load onto any of the factors. See Table 6 for factor array.

Q-Sort Interpretation

Factor one: Medically oriented (25% of variance).

Fifteen participants loaded onto factor one. The professional occupations of these participants were: six clinical psychologists/psychological therapists, five nurses, two mental health support workers, and two social workers. Participants within the medically oriented factor were most concerned with coping with behaviours and emotions associated with borderline personality disorder diagnosis. This included coping with affect regulation, such as 'being able to cope with strong feelings', and 'having more stable and balanced emotions', and behavioural features often associated with a diagnosis of borderline personality disorder such as 'self-harming less', and 'having less suicide attempts'. Post-sort interviews identified these

aspects of borderline personality disorder as the ones staff believed patients struggled with most, making coping with these characteristics central to recovery: "*One of the things that they seem to struggle most with is when things go wrong and coping with their extremes of emotion, and that because they're so aversive and unpleasant they're driven to all sorts of behaviours to try and reduce the pain*".

Participants in the medically oriented factor ranked 'taking risks' as less important for recovery, with one person stating explicitly: "*We want to get them out of taking risks*". However, post-sort interviews suggested that others interpreted the 'risk' statement differently: "*Could be agree or disagree- especially for somebody with personality disorder it could be risky behaviour or positive risk taking"*. Positive risk-taking in a therapeutic context was construed as important to recovery, but the risky behaviours associated with borderline personality disorder were viewed in a negative manner.

Factor two: Well-being oriented (21% of variance).

Thirteen participants loaded onto factor two, consisting of: six clinical psychologists/psychological therapists, three mental health support workers, two occupational therapists, one social worker, and one nurse. Participants in the well-being oriented group agreed with statements that reflected general recovery principles, such as 'having a meaningful life', 'personal growth and discovery', 'having goals in life', 'belief in one's self', 'feeling accepted', and 'feeling hopeful about the future'. These participants believed that having goals in life was more important than achieving goals, and this related to having aspirations for the future: "*A lot of the work needs to be around exploring what they want from their lives, how they want to be first, to have those goals in mind*." Participants also discussed how these statements were important to well-being for everyone, regardless of diagnosis: *"At times,*

maybe people are focusing too much on what's specific about mental health disorders and around these difficulties, there is a person". Staff noted that the statements they endorsed were important to their own well-being, as well as people with borderline personality disorder.

Relationships with oneself were considered to be very important to participants in this group. Participants noted that patients often lacked an understanding of themselves and their identity due to past trauma: "*A lot of people I work with with personality disorder, they've had such a traumatic thing that's led to the difficulties that it fractures their sense of self and their identity.*" 'Understanding oneself' and 'learning to live with oneself' were therefore vital components of recovery, and relationships with oneself were seen as being more important than relationships with others.

Reducing behavioural features of borderline personality disorder, such as self-harm and suicide attempts were ranked as less important to recovery by participants loading onto this factor. This belief was a distinct contrast from participants in the medically oriented factor, which viewed reducing behavioural features of borderline personality disorder as very important to recovery. Post-sort interviews revealed that participants within the well-being oriented factor believed that by engaging with other more important aspects of recovery, negative behaviours would eventually be diminished:

> *"I don't put them up there (suicide and self-harm). Because they are the result of these kinds of things - having a meaningful life and having proper quality of life is really important. And once you've got that, and you trust other people and you feel heard and feel validated, and all those things then these things naturally come".*

Some participants also believed that self-harm sometimes played a role in helping people with borderline personality disorder to manage strong emotions: "*I didn't put it in disagree because I think people should self-harm… Until these people get to go through a period of growth and recovery and have other coping strategies for dealing with their emotions, self-harming serves a good purpose.*"

Consensus statements.

Although participants in the medically oriented and well-being oriented groups agreed with different statements, there was large consensus on the statements that they viewed as less important to recovery. 'Having no difficulties' was the most disagreed statement for participants of both factors. Post-sort interviews revealed that participants believed that this statement was misleading as it was not realistic for anyone regardless of borderline personality disorder diagnosis: "*Having no difficulties, that just doesn't make sense for anybody I don't think. That's just such an ideal*". Participants believed that the focus of recovery was on coping with difficulties, rather than not experiencing any: "*To be recovered isn't to have no difficulties, it's to cope with the difficulties that you do have*".

Statements associated with engaging in socially-valued activities were viewed as less important to recovery for both factors. Statements such as 'doing enjoyable activities', 'having "me" time', and 'feeling alert and alive' were ranked negatively. Participants in both subgroups held a strong belief that people did not have to be medication-free to be recovered from borderline personality disorder. Occupational statements such as 'being in employment (paid or unpaid)' and 'being in education or training' were also disagreed with. In qualitative interviews, some participants noted that these factors were goal-dependent: "*Some of it depends*

on the individual…whereas one person might feel very strongly that that's important for their recovery, another person might not at all".

Statements about basic needs such as 'being able to sleep', 'being in good physical health', 'having the right kind of place to live', and 'being financially comfortable' did not rank highly across factors. However, during interviews several participants reflected upon Maslow's hierarchy of needs (Maslow, 1954):

> *"If you think of Maslow's hierarchy of needs, if we don't have the basic needs met then there's no point plugging at above… And I suppose that's why in hospital, for example, that's what we offer them. We offer them that stability, we offer them the comfort, we feed them, they're warm, they're in a dry bed. So they're in a good position actually to engage in therapy. But if you're working with people in the community, and they're going back to a home where they can't afford the heating, where there's damp, so they're constantly having physical health problems, that probably needs to be the focus of the work first."*

Therefore, despite statements about basic needs being ranked as relatively less important to recovery in borderline personality disorder within the Q-sort, qualitative interviews highlighted that they were still seen as important to helping people engage in intervention.

'Living a life like others' was strongly believed to be less important to recovery across both groups. Post-sort interviews revealed that this was because of the negative effects that comparisons with others could have upon people: "*Comparing to other people can be really detrimental to recovery sometimes…if you're trying to live a life like others, it's probably a bit*

of a fantasy". Participants noted that people with borderline personality disorder should focus on their own goals for recovery instead: "*Rather than living a life like others, it's living a life that suits you best, and that you want*."

Statements about relationships, such as 'having good relationships', 'being able to trust others', and 'socialising more' were ranked in a neutral manner by both groups. Post-sort interviews identified some participants who felt strongly about the importance of relationships:

> "*Rejecting people was a defence mechanism to protect themselves, and it's become such as well-used defence mechanism in adulthood, that's all they know, is how to reject people because they've been rejected themselves, and that's what facilitates and fuels*".

However the importance of relationships in recovery from borderline personality disorder was not widely held by participants.

Discussion

The study aimed to investigate staff perceptions of recovery in borderline personality disorder using Q methodology. Two main aspects of recovery were emphasised by different groups of participants; one focused on reductions in behaviours associated with the diagnosis and the other associated with improvements in general well-being. Both groups envisaged that people with borderline personality disorder could recover despite continued impairments in everyday functioning.

The finding that the medically oriented group of participants conceptualised recovery in terms of reducing specific difficulties associated with a diagnosis of borderline personality

disorder, such a self-harming behaviour and affect regulation, is consistent with some previous investigations of the meaning of recovery in the context of borderline personality disorder. Although research into other serious mental illnesses has found that symptom reduction was not viewed as important to recovery (Todd, Jones & Lobban, 2012; Wood et al., 2013), qualitative research into recovery in personality disorder has found that some patients diagnosed with borderline personality disorder believe that a reduction in symptoms is a key aspect of their recovery (e.g. Katsakou et al., 2012; Turner et al., 2011).

The finding that the participants who identified with the well-being oriented group conceptualised recovery in line with personal recovery principles, such as hope (Hobbs & Baker, 2012; Pitt et al., 2007), identity (Bonney & Stickley, 2008), and having a meaningful life (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011) is also consistent with previous findings in the context of severe mental illness. It is notable that this group placed importance on relationships with oneself, however relationships with others were seen as being less important to recovery. Relationships and sense of self are often cited as highly important to recovery within the recovery literature which focuses on individual's support networks, reducing isolation and the positive effects of relationships upon identity (Repper & Perkins, 2003). A potential explanation for the perceived limited importance of relationships with others in recovery from borderline personality disorder may be that staff believe that improved relationships will be achieved as a result of engaging in other activities that were ranked more highly with the Q-sort. For example, having an improved relationship with oneself, learning to live with oneself, and attaining personal growth may lead to developing better relationships with others.

This study identified a consensus between participants on aspects that were considered less important to recovery in borderline personality disorder. Socially-valued activities, such as work and education, were not perceived to be as important to recovery for this patient group relative to other items. These views are inconsistent with qualitative research by Larivière et al. (2015), which suggested that involvement in meaningful activities such as employment and education was a key dimension of recovery in borderline personality disorder for patients themselves. The views expressed by staff in the present study perhaps indicate that they do not expect that patients with borderline personality disorder are capable of engaging with these activities or achieving 'normal' functioning. Such perceptions are consistent with previous research by Markham (2003), who found that nurses were less optimistic about what patients with borderline personality disorder can achieve compared to patients diagnosed with depression or schizophrenia. Alternatively, engagement in occupational activities may be viewed as something to be achieved later in the process of recovery, making it less important in comparison to other more highly-ranked items.

Clinical implications

The differing conceptualisations of recovery highlight that it is important that staff members are able to identify what is important to an individual patient at a particular point in time. The use of therapies that focus solely on clinical symptoms, or alternatively do not emphasise symptom reduction enough, may not target the aspects that an individual places importance on for their own recovery. Clinical tools that staff could use with service users to help people diagnosed with borderline personality disorder think about their own recovery issues would be useful in this respect. Such approaches to assessment would also be consistent with the growing movement in clinical practice for individualised approaches to care

(Department of Health, 2012) and increased collaboration between service users and staff (Lipczynska, 2011).

The finding that staff who work with people with borderline personality disorder differ in their views on what is important to recovery in this group is important as care is often provided by a multi-disciplinary team (MDT) of staff and the literature on highlights the importance of a consistent team approach to patient care to help manage patients' relationship difficulties (O'Brien, 1998; National Collaborating Centre for Mental Health, 2009). The process of developing a 'team formulation' could be used to create a shared understanding of an individual patient's needs and goals for recovery, and help MDTs to develop consistent approaches to working with patients diagnosed with borderline personality disorder. Team formulation involves staff teams setting aside dedicated time to work to together to identify the full range of biopsychosocial factors responsible for each patients' difficulties and using this information to plan treatment. The practice of engaging in team formulation is consistent with the principles of person-centred care as it encourages staff to look beyond the patient's symptoms of illness and appreciate their unique life experiences, needs, strengths, goals and values. As a result treatment plans informed by formulations are tailored to the patient's individual needs and circumstances at that particular point in time. Team formulation is currently recommended by many health organisations (Health Professions Council, 2009; British Psychological Society, 2010), and has been endorsed as a way of minimising disagreements between mental health teams across many mental health problems, including personality disorder (Willmot, 2011).

Limited focus on the importance of relationships to recovery in borderline personality disorder suggests that further staff training and supervision may be needed which is specifically

focused on the role of relationships with others in borderline personality disorder and how best to support patients to achieve their relationship goals. This training and supervision should also aim to promote a hopeful message about the capacity of people with borderline personality disorder to function successfully in everyday social environments and as such achieve socially valued goals.

Strengths and limitations

To our knowledge, this is the first Q-sort study to investigate perceptions of recovery in staff working with patients diagnosed with borderline personality disorder. The study explored views of staff from a range of different professional groups, trusts and services. The use of qualitative interviews in addition to the Q-sort was useful because it allowed for greater understanding when interpreting the data. The researcher's presence during the Q-sort task meant that the researcher was able to answer questions about the meaning of statements, and further their understanding of participants' subjectivity. Using Q methodology and using a range of statements about recovery gave participants a wide variety of perspectives to choose from and rank, which may have been otherwise omitted.

The aim of this research was to address the gap in the literature of staff perceptions of recovery in borderline personality disorder. Future research could build upon this by comparing the beliefs of staff with those of patients with borderline personality disorder. Administering the same items used within the present paper to a group of patients could help us to understand the similarities and differences between staff and patients' perceptions of recovery.

The biggest limitation of this study was the use of opportunistic sampling to recruit participants. Our sample was not representative of the general population, and this was evident

from the under-representation of people from non-White backgrounds in this research. Perspectives from people of a broader range of ethnic backgrounds would have been valuable due to cultural differences in perceptions of recovery discovered in previous research (Lapsley, Nikora, & Black, 2002; Leamy et al., 2011). Future research should incorporate a more diverse demographic sample of participant views to determine whether the factors discovered in the present study are important across ethnicities and cultures.

Furthermore, although the study sought to include the views of a diverse range of staff involved in the intervention of borderline personality disorder, it did not reflect the views of psychiatrists. Views from psychiatrists may be particularly interesting to sample because of their role in the diagnosis of borderline personality disorder, which may give them influence over how a patient views their opportunities for intervention. Their educational background is based on medical training, which may create differences in perspectives over other educational backgrounds, such as psychology. Further studies could therefore aim to engage this participant population to compare whether their perspectives on recovery in borderline personality disorder are different to those found in the present study.

Conclusions

This research fulfilled the study aims of exploring perceptions of recovery in staff working with patients with borderline personality disorder, and identified two perspectives that highlighted aspects that were believed to be most important to recovery. Coping with behaviours associated with a diagnosis of borderline personality disorder was an important feature of recovery, along with features associated with general well-being such as having hope, goals, and an understanding of identity. Our conclusions are concurrent with previous qualitative research exploring recovery in personality disorder, but this study extends the

existing literature by exploring staff perspectives. It is also the first study of recovery in borderline personality disorder to use a Q methodology, enabling the identification of two distinct perspectives or approaches to recovery that may be relevant to consider when working with people diagnosed with borderline personality disorder.

Conflict of interest

None.

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Table 1

Q Set Themes

Theme	Subthemes			
Relationships	Family	Friends	People with similar difficulties	Pets
Activities	Enjoyable/social activities	Sport	Employment	Education
Symptoms	Drugs and alcohol	General mental health symptoms	Personality disorder related symptoms	
Coping skills				
Physical health	Personal care	Diet	Exercise	
Relapse	Support	Hospitalisation		
Understanding	Insight/knowledge	Being given information		
Hope	Future			

Roles	Identity	Acceptance	Independence/ responsibility	Self-esteem/self confidence
Society	Housing	Stigma/prejudice	Community	
Treatment	Access to services	Choice	Medication	
Achievements	Having goals	Achieving goals		
Religion				
Finance				

Table 2

Breakdown of Participants by Profession and Service Type

Profession	**Number (%)**	**Service Type**
Clinical psychologist and Psychological therapist	12 (41.38)	Psychotherapy department, community mental health team, adult mental health, inpatient secure service
Nurse	6 (20.69)	Community mental health team, recovery team, therapeutic community
Mental health support worker	6 (20.69)	Women's services, learning disabilities
Social worker	3 (10.34)	Recovery team, therapeutic community, third sector
Occupational therapist	2 (6.90)	Community mental health team

Table 3

*Overall Participant Demographics**

Characteristic	
Participant mean age in years (range)	38.73 (24-52)
Participant gender	58.62% female (n = 17)
Participant ethnic group	68.97% White British 13.79% White Other 6.90% White Anglo Irish 3.45% British Pakistani 3.45% Irish 3.45% Mixed Black African and White
Mean years of practice (range)	7.91 (1-24)

* *Data missing: age (3 participants); years of practice (5 participants).*

Table 4

*Breakdown of Factors by Participant Demographics**

Characteristic	Factor 1	Factor 2
Participant mean age in years (range)	42.21 (25-60)	35.64 (30-52)
Participant gender	60% female (n = 9)	53.85% female (n = 7)
Participant ethnic group	66.67% White British 20% White Other 6.67% Irish 6.67% White Anglo Irish	69.23% White British 7.69% White Anglo Irish 7.69% British Pakistani 7.69% Mixed White African and Black 7.69% White Other
Mean years of practice (range)	9.125 (1-24)	7.23 (3-20)
Profession	5 Clinical Psychologists or Psychological Therapists 5 Nurses 3 Mental Health Support Workers 2 Social Workers	7 Clinical Psychologists or Psychological Therapists 2 Mental Health Support Workers 2 Occupational Therapists 1 Nurse 1 Social Worker

** Data missing: age (1 participant factor 1, 2 participants factor 2); years of practice (3 participants factor 1, 2 participants factor 2).*

Table 5

Frequency Count and Percentage of Participants Endorsing each Statement

Q-sort item	**Total number endorsing each statement (+1, +2, +3, +4, +5)**	
	N	*%*
16. Being able to get on with life, despite having difficulties	25	86.2
17. Being able to cope with strong feelings (e.g. feeling sad or angry)	25	86.2
33. Feeling hopeful about the future	23	79.3
52. Being treated with dignity and respect by others	23	79.3
19. Being able to cope with stress/bad things happening	22	75.9
1. Having good relationships	21	72.4
18. Being able to cope with disturbing thoughts	21	72.4
15. Being able to manage conflict	20	69.0
26. Getting the support needed when things are hard	20	69.0

46. Belief in one's self	20	69.0
9. Having a meaningful life	19	65.5
14. Being able to stop and think before acting	19	65.5
28. Understanding one's self	19	65.5
29. Knowing what helps and what doesn't help	19	65.5
43. Having a sense of identity	19	65.5
42. Feeling able to make mistakes	18	62.1
24. Knowing how to stay well	17	58.6
25. Being able to ask for help when it's needed	17	58.6
40. Feeling accepted	17	58.6
11. Having more stable and balanced emotions	16	55.2
12. Having less suicide attempts	16	55.2
13. Self-harming less	16	55.2
2. Being able to trust others	15	51.7
31. Learning to live with one's self	15	51.7
34. Personal growth and discovery	15	51.7
45. Knowing ones good qualities	14	48.3
55. Having goals in life	14	48.3

3. Having belief from others	13	44.8
20. Being able to sleep	13	44.8
44. Becoming less self-critical	13	44.8
23. Taking care of self	12	41.4
32. Trusting in one's self	11	37.9
41. Having inner peace	11	37.9
47. Making choices for self	11	37.9
10. Stopping addictive behaviour (e.g. gambling, shopping alcohol, drugs)	10	34.5
21. Doing things differently	10	34.5
53. Having choices in care	10	34.5
38. Taking risks	9	31.0
48. Being independent	9	31.0
50. Freedom from prejudice	9	31.0
7. Doing enjoyable activities	8	27.6
27. Learning from mistakes	8	27.6
51. Feeling part of one's community	8	27.6
4. Socialising more	7	24.1

49. Having the right kind of place to live	7	24.1
56. Achieving goals	7	24.1
37. Feeling alert and alive	6	20.7
39. Knowing when it is the right time to make important changes	6	20.7
22. Being in good physical health (e.g. exercising, eating healthily)	5	17.2
35. Having setbacks	4	13.8
8. Having ‘me’ time	3	10.3
58. Being financially comfortable	3	10.3
6. Being in education or training	2	6.9
36. Living a life like others	2	6.9
5. Being in employment (paid or unpaid)	1	3.4
54. Being medication free	1	3.4
57. Having religion and/or faith	1	3.4
30. Having no difficulties	0	0

Table 6

Factor Array

Statement	**Factor 1**	**Factor 2**
1. Having good relationships	+2	+2
2. Being able to trust others	+2	0
3. Having belief from others	+1	-1
4. Socialising more	0	-2
5. Being in employment (paid or unpaid)	-3	-3
6. Being in education or training	-3	-4
7. Doing enjoyable activities	-1	-1
8. Having "me" time	-3	-3
9. Having a meaningful life	0	+5
10. Stopping addictive behaviour (e.g. gambling, shopping, alcohol, drugs)	+2	-4
11. Having more stable and balanced emotions	+5	-2
12. Having less suicide attempts	+3	-1
13. Self-harming less	+4	-3
14. Being able to stop and think before acting	+4	0

15. Being able to manage conflict	+3	+1
16. Being able to get on with life, despite having difficulties	+4	+5
17. Being able to cope with strong feelings (e.g. feeling sad or angry)	+5	+3
18. Being able to cope with disturbing thoughts	+3	+2
19. Being able to cope with stress / bad things happening	+5	+1
20. Being able to sleep	+2	-1
21. Doing things differently	0	-3
22. Being in good physical health (e.g. exercising, eating healthily)	-2	-2
23. Taking care of self	+1	0
24. Knowing how to stay well	+3	0
25. Being able to ask for help when it's needed	+2	+1
26. Getting the support needed when things are hard	+1	+4
27. Learning from mistakes	-2	0
28. Understanding one's self	+1	+5
29. Knowing what helps and what doesn't help	+1	+2

30. Having no difficulties	-5	-5
31. Learning to live with one's self	+1	+3
32. Trusting in one's self	-1	0
33. Feeling hopeful about the future	+3	+4
34. Personal growth and discovery	-2	+4
35. Having setbacks	-4	-1
36. Living a life like others	-4	-5
37. Feeling alert and alive	-2	-2
38. Taking risks	-4	+1
39. Knowing when it is the right time to make important changes	-1	-1
40. Feeling accepted	+1	+3
41. Having inner peace	-2	-1
42. Feeling able to make mistakes	-1	+3
43. Having a sense of identity	+4	+3
44. Becoming less self-critical	0	0
45. Knowing ones good qualities	-2	+2
46. Belief in one's self	0	+4

47. Making choices for self	0	+1
48. Being independent	-1	-2
49. Having the right kind of place to live	-1	-2
50. Freedom from prejudice	-3	0
51. Feeling part of one's community	-4	+1
52. Being treated with dignity and respect by others	+2	+2
53. Having choices in care	-1	+2
54. Being medication free	-5	-5
55. Having goals in life	0	+1
56. Achieving goals	0	-3
57. Having religion and/or faith	-5	-4
58. Being financially comfortable	-3	-4

Not important **Neutral** **Very important**

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

Figure 1. Q-Sort Distribution Grid